

Medical History continued: Do you have any history of:

- | | | | |
|-------------------------|--|------------------|--|
| 11. High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | 12. Seizures | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Kidney Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | 14. Stroke | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 15. Liver Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | 16. Tuberculosis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 17. Pneumonia | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |

Comments

- | | | |
|---|--|-------|
| 18. Visual or hearing difficulty | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 19. Shortness of breath or chronic cough | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 20. Chest pain or fainting spells | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 21. Irregular heart beat or murmur | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 22. Vomiting blood, dark stools, or heartburn | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 23. Urinary discomfort, bleeding, or frequency | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 24. Back, neck, or joint pains | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 25. Fractured bones or joint dislocation | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 26. Unusual skin growths or rashes | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 27. Headaches or dizziness | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 28. Experience numbness or muscle weakness | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 29. Gynecological problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 30. Emotional problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 31. List any other conditions not listed above: | | _____ |

Tests and Immunizations: Please check box of those you have had and enter year

- | | |
|--|---|
| <input type="checkbox"/> Tetanus shot: _____ | <input type="checkbox"/> Rabies vaccination series: _____ |
| <input type="checkbox"/> TB test: _____ | <input type="checkbox"/> Hepatitis B: _____ |
| <input type="checkbox"/> Chest x-ray: _____ | <input type="checkbox"/> Influenza vaccine: _____ |

Occupational History: Do you know or have you ever worked with any of the following agents/hazards? If so, please check box and state when you last worked with the agent and how long.

- | | |
|--|--|
| <input type="checkbox"/> Asbestos _____ | <input type="checkbox"/> Exhaust _____ |
| <input type="checkbox"/> Biological agents/hazards _____
(Type _____) | <input type="checkbox"/> Formaldehyde _____ |
| <input type="checkbox"/> Excessive heat _____ | <input type="checkbox"/> Pesticides _____ |
| <input type="checkbox"/> Excessive noise _____ | <input type="checkbox"/> Radioactive material _____
solvents (Type _____) |

I understand that this physical examination is not designed, nor intended, to replace a regular physical examination, or routine medical care, by my private physician. I understand that this examination and all subsequent examinations are highly specific to evaluate my ability to perform certain tasks noted in my job description. This examination will not cover all aspects of a full physical examination.

Signature: _____ Date: _____